

**Department of Health and Family Services  
Office of Strategic Finance**

PO Box 7850  
Madison WI 53707-7850  
Phone (608) 266-3816  
Fax (608) 267-0358

**Date:** August 8, 2001

**To:** Family Care Pilots & Screen Leads

**From:** Monica Deignan  
Center for Delivery Systems Development

**Subject:** Required Protocols to Document and Report the Target Group of Family Care Enrollees

As part of the Family Care functional assessment process, Resource Centers have to document and report the target group(s) of each individual for whom they perform a functional screen. In addition, in eligibility determination, the most appropriate waiver for an individual is a required entry by the Economic Support Worker on the ANCW screen in CARES. And finally, the waiver that is most appropriate for an individual is a required entry by CMOs for each member in field 26 on HSRS.

The attached document provides guidance for how an individual's target group, and thus the waiver through which they receive services, are to be assigned initially by the Resource Center, and potentially changed by the CMO. The determination is relatively straightforward in most cases, but can be a bit obscure for people with developmental disabilities. Most will be served in HCBS waivers for people with developmental disabilities, but others may be served in HCBS waivers for people who are aged or people with physical disabilities if they have no active treatment needs. The federal Centers for Medicare & Medicaid Services (CMS) -- formerly the Health Care Financing Administration (HCFA) -- routinely audits to ensure that waiver participants actually belong to the target group served by the waiver in which they are enrolled.

A related concern for CMOs is that residential facilities with more than four beds (or 8 beds with a waiver from the Department) are not allowable living arrangements in developmental disabilities waivers, but are allowable in elderly/physical disabilities waivers. A person with developmental disabilities can only be served in a larger facility if he or she is enrolled in an elderly/physical disabilities waiver. But, a person with developmental disabilities may be served in an elderly/physical disabilities waiver only if the individual has been determined to need no active treatment. CMS also routinely audits to ensure that waiver participants are not served in unallowable facilities. If federal funding is disallowed because an enrollee is served in an unallowable facility, the CMO will be responsible for that disallowance, and an adjustment made during year-end reconciliation.

Please review the attached protocols with relevant staff and incorporate them into your operating protocols. If you have questions, please contact Charles Jones at 608/266-0991 (E-mail: [jonescm@dhfs.state.wi.us](mailto:jonescm@dhfs.state.wi.us)).

cc: Family Care Managers Team  
Jim Jones, DHCF/BHCE  
Sharon Hron, DHCF/BHCE  
Heidi Herziger, DHCF/BHCSO  
CDSD Family Care Staff  
Ann Pooler, Center for Excellence  
Sarah Benedict, Center for Excellence

#### Attachments

I:\osfcdsd\family care\demos\correspondence\nat determinations.doc

## **Family Care Protocols for Reporting Target Group and Appropriate Waiver and the Need of People with Developmental Disabilities for Active Treatment**

### **Required Reporting:**

#### *Resource Center*

1. In initial determination and redetermination of level of care on the functional screen, for each person screened, in the Target Group Question check all target groups that apply, for the purpose of recording information about persons screened.
2. At Economic Support eligibility determination, respond to ES worker's inquiries about the appropriate waiver for some individuals, for the purpose of determining Medicaid eligibility.

#### *CMO*

1. In redetermination of level of care on the functional screen, for each person screened, check all target groups that apply in the Target Group Question, for the purpose of recording information about persons screened.
2. On HSRS, report the appropriate waiver code for each member on HSRS Field 26 for the purpose of federal waiver reporting.

### **Determining and Documenting Active Treatment Needs and Appropriate Waiver:**

The following guidelines are used to determine the appropriate waiver for serving an individual. This can be a bit tricky when there is both a DD and ICF level of care, since it requires determining whether the person can be classified as needing No Active Treatment (NAT).

<b>Target Group(s)</b>	<b>Level Of Care on FS</b>	<b>Needs Active Treatment?</b>	<b>Waiver</b>
DD or BI	DD1-3	n/a	CIP I*
DD or BI & Elderly or PD	DD1-3 & ICF	Yes	CIP I*
DD or BI & Elderly or PD	DD1-3 & ICF	No	COP-W
DD or BI & Elderly or PD	DD1-3 & ISN/SNF	n/a	COP-W
Elderly or PD	ISN/SNF/ICF	n/a	COP-W

\*CIP Ia for relocations from a State DD Center; CIP Ib for all others

#### *Resource Center*

Despite the fact that Resource Center screeners do not do a truly comprehensive assessment, they will still be able to make this determination fairly certainly in most instances using the attached criteria for making NAT determinations. If in doubt, screeners should make the assumption that the person does need active treatment and instruct Economic Support to record the person as someone who would be served by CIP Ia or Ib.

## *CMO*

CMOs report the appropriate waiver for each enrollee on HSRS. Since CMOs do a more comprehensive assessment, they will be in a better position to determine whether a person with developmental disabilities has active treatment needs. If the CMO determines that a person with developmental disabilities has no active treatment needs and should be served under an aging/physical disabilities waiver, it should:

1. Document in the enrollee's case record the criteria under which the interdisciplinary team has determined that no active treatment is needed.
2. Report the appropriate waiver for the enrollee on HSRS.
3. Check on enrollment reports to determine which waiver is reported on CARES.
4. If there is a discrepancy, ask the Resource Center to have the CARES entry revised. (The Resource Center will forward this request to ES.)

## **Criteria for Determining Whether a Person with Developmental Disabilities Need Active Treatment Or Can Be Classified as Needing No Active Treatment (NAT)<sup>1</sup>**

### General Rule:

The federal government has stated that for people with developmental disabilities the only exceptions to active treatment are for people with:

1. Such severe and chronic medical needs as to require SNF or higher level nursing care; or
2. Physical and mental incapacitation due to advanced age, whose needs are similar to those of geriatric nursing home residents.

### Specific Criteria:

The following are criteria that can be used to determine whether a person with developmental disabilities needs active treatment. A person can be classified as needing no active treatment if he or she is:

1. Elderly (generally over age 65) with a combination of factors which would indicate the individual has reached his or her maximum potential and would no longer benefit from active treatment. Such factors may include:
  - a) More than ten years in a facility;
  - b) Degenerative health status;
  - c) Discharged from ICF/MR facility after the age of 55-60;
  - d) Individual has been discontinued from any service program due to a determination that he/she has reached maximum benefit;
  - e) Adaptive behavioral assessments by community service boards and other professionals (QMRPs, psychologists) indicate that the individual has reached his/her maximum potential and the major portion of care is maintenance of present skills and no further growth is expected.
2. Terminally ill.
3. A person with a related condition, such as epilepsy, brain damage, autism or cerebral palsy who is not mentally retarded and is competent to handle his or her own affairs.

---

<sup>1</sup> Care managers who have worked with COP-W/CIP II may be familiar with the process for NAT determinations. However in Family Care, NAT determinations do not have to be sent to the Bureau of Aging and Long Term Care Resources, but are simply documented in the enrollee's case record.